Diabetes

Self management goals

Patient name _____

Date of birth _____

Daytime phone # _____

Address _____

City/State/Zip _____

Today's date _____

Follow up time frame:

_____

_____

_____

_____

Goal setting

Please choose goals you would like to work on to better manage your diabetes.

⑨ I will exercise (walk) 30 minutes _____ days per week. If I notice chest pain, shortness of breath, or chest tightness, I will seek medical attention.

⑨ I will check my feet daily. If I notice a sore or irritation I will seek medical attention.
I will visit a podiatrist yearly, or as instructed.

⑨ I will follow my diabetic and low fat diet to reduce my blood sugar and cholesterol.

⑨ I will try to obtain my ideal body weight. I will lose _____ pounds by my next office visit.

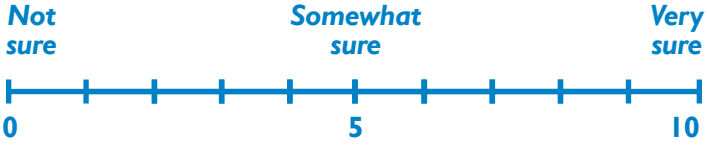
⑨ I will stop smoking.

⑨ I will have an eye exam every year or as indicated.

⑨ I will check my blood sugar _____ times a day and will call if the results are consistently below _____ or above _____. (ADA recommendation is to maintain a blood sugar level between 80 and 130.)

2. Choose your confidence level:

I think I can succeed at this goal:



3. Fill in the following for your chosen goal:

What: _____

_____

When: _____

_____

How much: _____

_____

How often: _____

_____

Barriers to meeting these goals: _____

_____

_____

_____

Clinician signature

The Physician Alliance
Dedicated to Improving Michigan's Health